Complete Summary

GUIDELINE TITLE

Assessment of function. In: Evidence-based geriatric nursing protocols for best practice.

BIBLIOGRAPHIC SOURCE(S)

Kresevic DM. Assessment of function. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 23-40. [48 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Kresevic DM, Mezey M. Assessment of function. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 31-46.

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SCOPE

DISEASE/CONDITION(S)

Functional decline

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Geriatrics
Nursing
Physical Medicine and Rehabilitation

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Occupational Therapists
Physical Therapists
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To maximize the physical functioning, prevent or minimize decline in activities of daily living function, and plan for future care needs

TARGET POPULATION

Hospitalized older adults

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Comprehensive functional assessment
    - Basic activities of daily living (ADL)
    - Instrumental ADL
    - Mobility
2. Strengths, need for assistance
3. Baseline functional status
    - Katz ADL Index
    - Functional Independence Measure (FIM™)
    - Lawton Instrumental Activities of Daily Living (IADL) assessment
    - "Get-up and Go" test for ambulation
4. Standard instruments to assess function
5. Interdisciplinary/multidisciplinary collaboration

Management

1. Maximization of function and prevention of decline
    - Daily routine
    - Education of elders, family, and formal caregivers
    - Activity
    - Minimization of bed rest
    - Alternatives to physical restraints

- Pain
- Environmental design
- Regaining baseline functional status
- Physical and occupational therapies

2. Helping older individuals cope with functional decline
    - Determining realistic functional capacity
    - Caregiver education and support
    - Community resources
    - Documentation
    - Protein and caloric intake

MAJOR OUTCOMES CONSIDERED

- Performance of activities of daily living (ADL)
- Performance of instrumental activities of daily living (IADL)
- Functional decline
- Delirium
- Use of physical restraints
- Use of foley catheters
- Readmission rate
- Quality of life
- Morbidity
- Mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Although the AGREE instrument (which is described in Chapter 1 of the original guideline document) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus the AGREE instrument has been expanded for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent

to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): In this update of the guideline, the process previously used to develop the geriatric nursing protocols has been enhanced.

Levels of evidence (I –VI) are defined at the end of the "Major Recommendations" field.

Assessment Parameters

- Comprehensive functional assessment of elders includes independent performance of basic activities of daily living (ADLs), social activities, or instrumental activities of daily living (IADLs), the assistance needed to accomplish these tasks, and the sensory ability, cognition, and capacity to ambulate (Campbell, et al., 2004 **[Level I]**; Doran et al., 2006 **[Level VI]**; Freedman, Martin, & Schueni, 2002 **[Level I]**; Kane & Kane, 2000 **[Level VI]**; Katz et al., 1963 **[Level I]**; Lawton & Brody, 1969 **[Level IV]**; Lightbody & Baldwin, 2002 **[Level VI]**; McCusker, Kakuma, & Abramowicz, 2002 **[Level I]**; Tinetti & Ginter, 1988 **[Level I]**).
- Basic ADL
    - Bathing
    - Dressing
    - Grooming
    - Eating
    - Continence
    - Transferring
- IADLs
    - Meal preparation
    - Shopping
    - Medication administration
    - Housework
    - Transportation
    - Accounting
- Mobility
    - Ambulation
    - Pivoting
- Elderly patients may view their health in terms of how well they can function rather than in terms of disease alone. Strengths should be emphasized as well as needs for assistance (Depp & Jeste, 2006 **[Level I]**; Pearson, 2000 **[Level VI]**).
- The clinician should document baseline functional status and recent or progressive declines in function. (Graf, 2006 **[Level V]**).
- Function should be assessed over time to validate capacity, decline, or progress (Applegate, Blass, & Franklin, 1990 **[Level VI]**; Callahan et al., 2002 **[Level VI]**; Kane & Kane, 2000 **[Level VI]**).
- Standard instruments selected to assess function should be efficient to administer and easy to interpret. They should provide useful practical information for clinicians and should be incorporated into routine history taking and daily assessments (Kane & Kane 2000 **[Level VI]**; Kresevic &

Holder, 1998 **[Level VI]**). (See Function topic at www.ConsultGeriRN.org for tools.)
- Interdisciplinary communication regarding functional status, changes, and expected trajectory should be part of all care settings (Counsell et al., 2000 **[Level II]**; Kresevic & Holder, 1998 **[Level VI]**; Landefeld et al., 1995 **[Level II]**).
- Multidisciplinary team conferences including patient and family whenever possible (Covinsky et al., 1998 **[Level II]**; Kresevic & Holder, 1998 **[Level VI]**).

Care Strategies

Strategies to maximize functional status and to prevent decline:

- Maintain individual's daily routine. Help to maintain physical, cognitive, and social function through physical activity and socialization. Encourage ambulation, allow flexible visitation including pets, and encourage reading the newspaper (Kresevic & Holder, 1998 **[Level VI]**; Landefeld et al., 1995 **[Level II]**).
- Educate elders, family, and formal caregivers on the value of independent functioning and the consequences of functional decline (Graf, 2006 **[Level V]**; Kresevic & Holder, 1998 **[Level VI]**; Vass et al., 2005 **[Level II]**).
    - Physiological and psychological value of independent functioning.
    - Reversible functional decline associated with acute illness (Hirsch et al., 1990 **[Level VI]**; Sager & Rudberg, 1998 **[Level II]**).
    - Strategies to prevent functional decline: exercise, nutrition, pain management, and socialization (Kresevic & Holder 1998 **[Level VI]**; Landefeld et al., 1995 **[Level II]**; Tucker, Molsberger, & Clark, 2004; Siegler, Glick, & Lee, 2002 **[Level VI]**).
    - Sources of assistance to manage decline.
- Encourage activity including routine exercise, range of motion, and ambulation to maintain activity, flexibility, and function (Counsell et al., 2000 **[Level II]**; Landefeld et al., 1995 **[Level II]**; Pedersen & Saltin, 2006 **[Level I]**).
- Minimize bed rest (Bates-Jensen et al., 2004 **[Level VI]**; Covinsky et al., 1998 **[Level II]**; Landefeld et al., 1995 **[Level II]**; Kresevic & Holder, 1998 **[Level VI]**).
- Explore alternatives to physical restraints use (Covinsky et al., 1998 [Level II]; Kresevic & Holder, 1998 **[Level VI]**).
- Judiciously use medications, especially psychoactive medications in geriatric dosages (Inouye, 1998 **[Level III]**).
- Assess and treat for pain (Covinsky et al., 1998 **[Level II]**).
- Design environments with handrails, wide doorways, raised toilet seats, shower seats, enhanced lighting, low beds, and chairs of various types and height (Kresevic et al., 1998 **[Level VI]**, Cunningham & Michael, 2004 **[Level I]**).
- Help individuals regain baseline function after acute illnesses by using exercise, physical therapy consultation, nutrition, and coaching (Conn et al., 2003 **[Level I]**); Engberg et al., 2002 **[Level II]**; Hodgkinson, Evans, & Woods, 2003 **[Level I]**; Forbes, 2005 **[Level VI]**; Kresevic et al., 1998 **[Level V]**).

- Obtain assessment for physical and occupational therapies needed to help regain function (Covinsky et al., 1998 **[Level II]**).

Strategies to help older individuals cope with functional decline:

- Help older adults and family members determine realistic functional capacity with interdisciplinary consultation (Kresevic & Holder, 1998 **[Level VI]**).
- Provide caregiver education and support for families of individuals when decline cannot be ameliorated in spite of nursing and rehabilitative efforts (Graf, 2006 **[Level V]**).
- Carefully document all intervention strategies and patient responses (Graf, 2006 **[Level V]**).
- Provide information to caregivers on causes of functional decline related to acute and chronic conditions (Covinsky et al., 1998 **[Level II]**).
- Provide education to address safety care needs for falls, injuries, and common complications. Short-term skilled care for physical therapy may be needed; long-term care settings may be required to ensure safety (Covinsky et al., 1998 **[Level II**]).
- Provide sufficient protein and caloric intake to ensure adequate intake and prevent further decline. Liberalize diet to include personal preferences (Edington et al., 2004 **[Level II]**; Landefeld et al., 1995 **[Level II]**).
- Provide caregiver support via community services, such as home care, nursing, and physical and occupational therapy services, to manage functional decline. (Covinsky et al., 1998 [**Level II]**; Graf, 2006 **[Level V]**)

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Patients

- Maintain safe level of activities of daily living and ambulation
- Make necessary adaptations to maintain safety and independence including assistive devices and environmental adaptations
- Highest quality of life despite functional level

Providers

- Increased assessment, identification, and management of patients susceptible to or experiencing functional decline. Routine assessment of functional capacity despite level of care
- Ongoing documentation and communication of capacity, interventions, goals, and outcomes
- Competence in preventive and restorative strategies for function
- Competence in assessing safe environments of care that foster safe independent function

Institution

- System-wide incorporation of functional assessment
- Reduced incidence and prevalence of functional decline
- Decreased morbidity and mortality rates associated with functional decline
- Reduced use of physical restraints, prolonged bed rest, foley catheters
- Decreased incidence of delirium
- Increased prevalence of patients who leave hospital with baseline or improved functional status
- Decreased readmission rate
- Increased early utilization of rehabilitative services (occupational and physical therapy)
- Support of institutional policies/programs that promote function
- Evidence of geriatric sensitive physical care environments that facilitate safe independent function such as caregiver educational efforts and walking programs

- Evidence of continued interdisciplinary assessments, care planning, and evaluation of care related to function

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Kresevic DM. Assessment of function. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 23-40. [48 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

Hartford Institute for Geriatric Nursing - Academic Institution

GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Denise Kresevic

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Kresevic DM, Mezey M. Assessment of function. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 31-46.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site.

Copies of the book *Geriatric Nursing Protocols for Best Practice*, 3rd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Katz index of independence in activities of daily living (ADL). Try this: best practices in nursing care to older adults. 2007. Electronic copies available from the Hartford Institute for Geriatric Nursing Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on May 30, 2003. The information was verified by the guideline developer on August 25, 2003. This guideline was updated by ECRI Institute on June 18, 2008. The updated information was verified by the guideline developer on August 4, 2008.

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